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Cognitive Behavioral Therapy (CBT) is a form of psychotherapy that focuses on the role of cognition in the expression of emotions and behaviors. CBT assumes that maladaptive feelings and behaviors develop through cognitive processes which evolve from interactions with others and experiences in the environment. The goal of therapy is to identify the maladaptive cognitive process and to learn new ways of perceiving and thinking about events. These new ways of thinking will lead to more positive behavioral and emotional responses.

CBT is a general classification of psychotherapy. It encompasses several different approaches that share the same theoretical underpinnings. Among the cognitive behavioral approaches being practiced today are Rational Emotive Behavior Therapy, Cognitive Therapy, Rational Behavior Therapy, Rational Living Therapy, Schema Focused Therapy and Dialectical Behavior Therapy.

History of CBT

A precursor to the development of CBT was the emergence of Albert Bandura's Social Learning Theory. Unlike the prevailing psychodynamic or behavioral views of psychological disturbance, Bandura viewed people as consciously and actively interacting cognitively with their environments. He introduced the notion that cognitive mediation occurs in the stimulus-response cycle of human behavior. This suggestion that people *think* before they *do* offered a new target for therapeutic intervention and set the stage for the development of CBT.

Cognitive Behavioral Therapy has its origins in the work of Albert Ellis and Aaron T. Beck in the late 1950's and early 1960's. During that time, Albert Ellis, seeking an alternative to psychodynamic therapy which he viewed as indirect and inefficient, developed Rational Emotive Therapy (RET). Later termed Rational Emotive Behavior Therapy (REBT), Ellis' approach

emphasized the role of cognitions in determining a person's feelings and behaviors. Ellis was particularly influenced by the Stoic philosophy which held that people are upset not by events, but rather by the view they take of them. He was also influenced by the psychotherapist Alfred Adler, who posited that behavior stems from thought.

REBT holds that psychological disturbances stem from irrational beliefs. These irrational beliefs usually take the form of an individual's insistence that things *should*, *ought*, or *must* be different from the way they are. Cognitive errors including overgeneralization, interpreting small events to have great meaning (i.e., believing that an everyday mistake is evidence of complete incompetence), and catastrophizing, turning a small problem into an insurmountable one, are targets of therapy. In REBT, the therapist directly confronts these irrational thoughts and unrealistic expectations.

Also influenced by the Stoicists, and Adler, Aaron T. Beck developed a structured, short-term, present focused treatment for depression. Beck's approach, termed Cognitive Therapy was based on Beck's observation that his patients with depression held idiosyncratic cognitive biases. From this, Beck developed a model of depression depicting a cognitive triad characterized by a negative view of the self, the world and the future, along with a perception of the self as inadequate, alone, and worthless. Beck maintained that similar systematic biases in information processing are characteristic of most psychological disorders. For example, anxiety disorders are characterized by a pervasive sense of physical or psychological danger while paranoid thinking involves a bias assuming that others are prejudiced, abusive or critical.

Whereas the REBT therapist actively confronts and attempts to persuade the client that his/her thinking is irrational, in Cognitive therapy the client is engaged in a spirit of collaborative empiricism. That is, through a combination of Socratic questioning and behavioral experimentation, the therapist and client work together to determine the accuracy (or inaccuracy) of the client's thoughts and beliefs. In the 1970's Donald Meichenbaum developed a treatment approach he termed Cognitive Behavior Modification. Meichenbaum's early research on the role of cognition in behavior originated in his observation of persons with schizophrenia engaging in self instruction in their efforts to maintain assigned "healthy talk" to receive reinforcements. Stemming from this observation, much of Meichenbaum's work centered on the internal dialog, or "self-talk" that underlies individual's affect and behavior and is the foundation for the development of coping skills. Meichenbaum suggested that cognitive behavior modification was aimed at creating a bridge between strictly behavioral and strictly cognitive treatment modalities and has been successfully applied in the treatment of anxiety, anger, and stress.

Applications of CBT

Over the years, CBT has been used to treat a wide variety of psychological disorders, across a variety of populations and settings. Among adults, it has been proven effective in the treatment of major depressive disorder, generalized anxiety disorder, social phobia, substance abuse, obsessive-compulsive disorder, and couples'/marital problems. CBT has also been applied to the treatment of post-traumatic stress disorder, personality disorders, chronic pain, antisocial behavior, hypochondria and schizophrenia. As previously noted, CBT uses performance-based procedures and structured sessions along with cognitive intervention techniques to produce changes in thinking, feeling and behavior. This model translates well to working with youth and their families. Cognitive Behavioral approaches adapt well to the demands of children's differing developmental levels. Although it provides structure for treatment, cognitive behavioral therapy is flexible allowing

for adaptations to meet individual client's developmental needs. With younger children the treatment process will likely have a behavioral emphasis, focusing on operant techniques to modify behavior. As cognitive abilities develop, the focus of therapy can shift to the mediating cognitions that determine emotion and behavior. It has been suggested that children as young as age 5 can benefit from cognitive behavioral therapy. For children who are not developmentally ready for more abstract forms of thinking, CBT focuses on concrete skills including problem solving and rehearsal of positive coping statements.

Although the research is less extensive than in the adult literature, CBT has been proven effective with children and youth across a variety of presenting problems in a variety of modalities. Youth ranging in age from preschool to college have benefited from CBT approaches provided to the individual, with their families, or in groups, and in outpatient or inpatient treatment settings. The efficacy of CBT in the treatment of childhood or adolescent aggression, anxiety, social anxiety, depression, obsessive-compulsive disorder, suicidal ideation and eating disorders has been empirically supported in a number of studies.

Principles of CBT

While there are mUltiple approaches to CBT, according to the National Association of Cognitive Behavioral Therapists (NACBT), they share several characteristics. First, CBT is based on the cognitive model. That is, feelings and behaviors stem from *thoughts*, not from external stimuli. This sets the stage for CBT's hopeful assumption that the individual can alter his/her feelings and behaviors, even in the face of intractable situations.

Second, CBT is time limited. Unlike psychoanalysis which can last for years, CBT extends for an average of 16 sessions, across types of presenting problems. Judith Beck notes that treatment for depression and anxiety generally ranges from four to 14 sessions. The time-limited nature of therapy holds true in applications with children and adolescents as well as adults, although protocols adapted from adult therapy approaches may need to be extended to allow for development of the therapeutic alliance and to build skills in meta-cognition and problem solving. Treatment protocols for youth depression and obsessive compulsive disorder generally entailing fewer than 20 session have been empirically supported.

Third, CBT recognizes the importance of an effective therapeutic relationship between therapist and client although this is not the focus of treatment. Factors contributing to a positive therapeutic relationship include warmth, empathy, caring, genuine regard and, particularly with youth, a collaborative spirit. The CBT therapist focuses on teaching the client to serve as his/her own therapist by identifying and modifying distorted thought patterns.

Similarly, CBT emphasizes collaboration and active participation. Client and therapist are viewed as a team. The client is actively engaged in the therapeutic process, with input on session topics and homework. According to Judith Beck, cognitive therapy teaches patients to identify, evaluate and respond to their dysfunctional thoughts and beliefs. In a spirit of collaborative empiricism, the therapist helps the client evaluate his thoughts by examining the evidence that either supports or refutes them. Cognitive behavioral therapists use Socratic questioning to develop an understanding of their clients' concerns and encourage clients to question themselves.

In addition to being collaborative and active, CBT is based on an educational model. The aim of therapy is to teach the client to be his/her own therapist, emphasizing relapse prevention. Positing that maladaptive behaviors and emotional reactions are learned, CBT aims to help the client unlearn the old reactions and develop new ones by

altering his or her cognitive responses.

Cognitive behavioral therapy is goal oriented and problem focused. Unlike its psychoanalytic predecessors, cognitive therapy maintains that the thoughts contributing to a patients' distress are not deeply buried in the unconscious. As a result, CBT emphasizes the present, and on ameliorating symptoms in the here and now rather than on lengthy analysis of the client's developmental history.

A related principle of CBT is that it is structured and directive. In keeping with its time-limited nature, CBT employs a specific agenda for each session. This consistency of structure facilitates generalization by providing a formula the client can use when acting as his or her own therapist after termination of therapy. The therapist and client generate the agenda collaboratively keeping the client's goals for therapy in mind. Further, CBT uses homework, tasks to be completed between therapy sessions.

Conclusion

CBT has rapidly increased in popularity over the last forty years. It enjoys strong empirical support, and the body of research into its efficacy is expanding with each passing year. Given symmetry between the time limited nature of CBT and the demands of cost containment and managed care, this growth seems likely to continue.

See also: Childhood depression; Desensitization; Obsessive-Compulsive Disorder (OCD)

Suggested Reading

Beck, A.T., and M.E. Weishaar (1995). Cognitive therapy. *In*: R.J. Corsini and D. Wedding (editors), *Current Psychotherapies* (5th ed.) (pp. 229-261). Itasca, Ill.: F.E. Peacock.

Beck, J.S. (1995). *Cognitive Therapy: Basics and Beyond*. New York: Guilford.

Friedberg, R.D., and J.M. McClure (2002). *Clinical Practice of Cognitive Therapy with Children and Adolescents: The Nuts and Bolts*. New York: Guilford.

Suggested Resources

The Association for Behavioral and Cognitive Therapies (ABCT)—http://www.aabt.org/aabt. The website of the Association for Behavioral and Cognitive Therapies provides an overview of the organization as well as resources about CBT and therapist referrals.

The Beck Institute for Cognitive Therapy and Research—http://www.beckinstitute.org. The Beck Institute offers cognitive behavior therapy training programs, conducts research on the efficacy of CBT and provides direct clinical services.

National Association of Cognitive Behavioral Therapists—http://www.nacbt.org. The website of the National Association of Cognitive Behavioral Therapists provides information on CBT and therapist referrals.